

- ☐ Initiate Waiver services
- ☐ Service Modification
 - ☐ Add a service
 - ☐ Increasing amount of service
 - ☐ Decreasing of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver Assistive Technology Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name: _____ Provider Number: _____

(if Medicaid Provider number is
assigned)

| | | |
|--|--------------|------------|
| Name: _____ | Start: _____ | End: _____ |
| Last, First MI | Date | Date |

Medicaid Number: _____

The individual must have at least one other MR Waiver service to receive this service.

| CHECK SERVICE TO BE PROVIDED | COST | OMR USE ONLY |
|--|------|--------------|
| <input type="checkbox"/> T1999 Assistive Technology only | | |
| <input type="checkbox"/> T1999 U5 Assistive Technology; Maintenance costs only | | |

Maximum Expenses = \$5,000 per CSP year Note previous expenses this CSP yr: _____

Reason for this request (attach documentation of recommendation by a qualified professional)

Documentation in the record that item/s requested are not covered by State Plan and not available from a DME provider.

☐ Yes ☐ No Explain as applicable: _____

Check the following as needed by the individual:

- ☐ Specialized medical equipment and ancillary equipment/supplies necessary for life support
- ☐ Durable/non-durable medical equipment and supplies
- ☐ Adaptive devices, appliances, and/or controls which enable an individual to be more independent in activities of daily living
- ☐ Equipment and devices which enable an individual to communicate more effectively

Describe the specific modifications, equipment, supplies and/or other services to be provided:

Comments:

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

| | | | | |
|------------------------------|-----------|-----------|---------|------|
| CSB Rep/Case Manager (print) | Signature | Phone No. | Fax No. | Date |
|------------------------------|-----------|-----------|---------|------|